

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 91

No. 200

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Pa.</i> COUNTY <i>Lancaster</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Carlsville</i> <i>just today</i>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Peguea, Pa.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) <i>Ralph Gordon Armstrong</i>		(First) <i>Ralph</i> (Middle) <i>Gordon</i> (Last) <i>Armstrong</i>	4. DATE OF DEATH <i>1/7/56</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SPECIFY <i>Married</i>	8. DATE OF BIRTH <i>7-7-1883</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>	11. BIRTHPLACE (State or foreign country) <i>Lancaster Co. Pa.</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13. FATHER'S NAME: <i>Oliver Armstrong</i>	
14. MOTHER'S MAIDEN NAME: <i>Susie McMillan</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>No</i>	
16. SOCIAL SECURITY NO.: <i>160</i>		17. INFORMANT & ADDRESS: <i>Leonard Armstrong, Willow Street</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause <i>Acute Coronary Thrombosis</i> (a) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
An antecedent cause(s) Diseases or conditions, if any, (b) <i>giving rise to the above cause</i> DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <i>19b. MAJOR FINDING OF OPERATION:</i>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg, etc., INJURY)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <i>R. Gordon</i>			
23. BURIAL, CREMATION, REMOVAL (Specify): <i>burial</i>		DATE THEREOF <i>1/11/56</i>	NAME OF CEMETERY OR CREMATORIAL <i>Mt. Cuba</i>
DATE REC'D BY LOCAL REG. <i>Jan. 7, 1956</i>		REGISTRAR'S SIGNATURE <i>Edward Fellow</i>	LOCATION (City, town, or county) <i>Pa.</i>
		24. FUNERAL DIRECTOR <i>Edward Fellow</i>	ADDRESS <i>Willington Rd.</i>
		Mrs. Ralph Recs	

BUREAU V. S.

JAN 17 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00459

478

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Cecil</u> MARYLAND		STATE <u>New Jersey</u> COUNTY <u>Salem</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>ELK Mills</u>		TOWN <u>Deep Water</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS <u>106 Harrison St.</u>	
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Henry</u> (Last) <u>Aument</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1 29 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 24, 1889</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Machinist Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>DuPont Cham. Co.</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George W. Aument</u>		14. MOTHER'S MAIDEN NAME: <u>ELLA B. Torbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>146-05-7741</u>	
17. INFORMANT & ADDRESS: <u>George Aument, Newark, Del.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
IMMEDIATE CAUSE <u>Garryng thrombosis (2nd attack)</u>		(A) DUE TO <u>Garryng thrombosis (2nd attack)</u>	
ANTECEDENT CAUSE (B) <u>Giving rise to the above cause</u>		(B) DUE TO <u>Garryng thrombosis (1st attack)</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) INJURY OCCUR?		(County) <u>Delaware</u> (State) <u>Del.</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 12, 1955</u> , to <u>Jan. 29, 1956</u> , that I last saw the deceased alive on <u>Jan. 17, 1956</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Ralph Aument Jr.</u> ADDRESS <u>Elkton, Maryland</u> DATE SIGNED <u>Jan. 30, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Survival</u>		DATE THEREOF <u>2/1/56</u> NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State) <u>Cherry Hill Methodist Church, Cherry Hill, N.J.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 1</u>		24. FUNERAL DIRECTOR ADDRESS <u>Walter J. Boen, Jr., Elkton, Md.</u>	
REGISTRAR'S SIGNATURE <u>H. Frazer</u>			

RECEIVED  
BUREAU V. S.

FEB 2 1956

RECEIVED FEB 2 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1800460

479

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

COUNTY Cecil

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR  
and give nearest town)LENGTH OF STAY  
(in this place)

TOWN Liberty Grove Rural

75 yrs.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS3. NAME OF  
DECEASED:(First)  
(Type or Print)

(Middle)

(Last)

## 4. SEX:

6. COLOR OR  
RACE:

Female

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.

widowed

## 8. DATE OF BIRTH:

Sept. 11, 1880

9. AGE last birthday

75

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

12. CITIZEN OF WHAT

COUNTRY

U.S.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired)

housewife

10B. KIND OF BUSINESS  
OR INDUSTRY:

Own home

11. BIRTHPLACE (State or foreign country):

Liberty Grove Md.

## 13. FATHER'S NAME:

Isaac Griest

## 14. MOTHER'S MAIDEN NAME:

Mary Caldwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

no

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

Mrs. Ross Montgomery

Liberty Gro

INTERVAL BETWEEN  
ONSET AND DEATH

1 year

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174 X

## IMMEDIATE CAUSE

(A)  
DUE TO

Carcinosis Herres -

## ANTECEDENT CAUSE (S)

(B)  
DUE TO

General Metastasis -

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

Myocarditis -

3 yrs

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY  
YES  NO 21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

## 21F. HOW DID INJURY OCCUR?

M.

## 22. I hereby certify that I attended the deceased from June 1954 to Jan 8, 1956 that I last saw the deceased

alive on Jan 8, 1956 and that death occurred at 6:15 A.M.

from the causes and on the date stated above.  
ADDRESS DATE SIGNED23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
Burial

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORI

## LOCATION (City, town, or county)

(State)

Jan. 12, 1956

Harmony Chapel Cem.

Rowlandville

Md.

24. FUNERAL DIRECTOR  
REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

J. E. Tyson

Rising Sun, Md.

RECEIVED  
SEARCHED  
INDEXED  
SERIALIZED  
FILED

BUREAU V. S

JAN 12 1968

DECEIVED

## CERTIFICATE OF DEATH

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information  
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Cecil</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Cecil</b>
CITY (If outside corporate limits, write RURAL OR, and give nearest town) <b>Perry Point</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Perry Point (V.A. Hospital)</b>	
LENGTH OF STAY (in this place) <b>31 yrs. 10 mo. 24 days</b>		STREET ADDRESS <b>(If rural give location)</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>50 Veterans Administration Hospital</b>			
3. NAME OF DECEASED: (Type or Print)	(First) <b>ANTONIO</b>	(Middle) <b>(NMI)</b>	(Last) <b>BENEDITTO</b>
4. DATE (Month) OF DEATH:	<b>January</b>	(Day) <b>27</b>	(Year) <b>19 56</b>
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>8-5-75</b>
9. AGE last birthday <b>80 yrs.</b>	10. KIND OF BUSINESS OR INDUSTRY: <b>Unknown</b>	11. BIRTHPLACE (State or foreign country): <b>Italy</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Unknown</b>		14. MOTHER'S MAIDEN NAME: <b>Unknown</b>	
13. FATHER'S NAME: <b>Unknown</b>		17. INFORMANT & ADDRESS: <b>Hospital Records, VAH, Perry Point, Md.</b>	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>490X</b> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH <b>5 to 6 days</b>	
(A) <b>Hemorrhage subdural subarachnoid, massive</b> Part I due to trauma Part II <b>Fractures multiple, of the skull</b> DUE TO		5 to 6 days	
(C) <b>Pneumonia lobar unresolved, right lower</b> <b>lobe</b> <b>Arteriosclerosis generalized</b>		7 to 10 days unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>VA M.</b>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <input checked="" type="checkbox"/> attended the deceased from <b>3-3</b> , 19 <b>24</b> to <b>1-27</b> , 19 <b>56</b> , and that death occurred at <b>6:45 P.M.</b> , from the causes and on the date stated above. SIGNATURE <b>W. OPPLER, Director, Professional Services M.D.</b> ADDRESS <b>VAH, Perry Point, Md.</b> DATE SIGNED <b>1-31-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1-31-56</b>	
NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>		LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)	
DATE REC'D BY LOCAL REGISTRAR <b>2-1-56</b>		REGISTRAR'S SIGNATURE <b>Irene E. Daugherty</b>	
24. FUNERAL DIRECTOR <b>Pennington &amp; Son</b>		ADDRESS <b>Holyoke de Grace, Md.</b>	

BUREAU V. S.

FEB 3 1956

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

481

00462

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY Cecil		MARYLAND		STATE Indiana	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		COUNTY Ripley	
TOWN Bainbridge		3 days		CITY (If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		TOWN Madison	
51 U. S. Naval Hospital		R.D. #1		(If rural give location)	
<b>3. NAME OF DECEASED</b> (First) Gertrude (Middle) Doll (Last) Benham			<b>4. DATE OF DEATH</b> 7 18 19 56		
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	
8. DATE OF BIRTH June 4, 1881		9. AGE last birthday 74 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Indiana		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Deceased (unknown)		
14. MOTHER'S MAIDEN NAME Deceased (unknown)			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		
16. SOCIAL SECURITY NO. -----			17. INFORMANT & ADDRESS Navy Records		
<b>18. MEDICAL CERTIFICATION</b>					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>331X</b> IMMEDIATE CAUSE (A) <b>CEREBRAL VASCULAR ACCIDENT GENERALIZED</b> ANTECEDENT CAUSE(S) DUE TO <b>ARTERIOSCLEROSIS</b> INTERVAL BETWEEN DISEASES OR CONDITIONS, IF ANY, (B) _____ ONSET AND DEATH GIVING RISE TO THE ABOVE CAUSE DUE TO APPROX. STATING UNDERLYING CAUSE LAST. (C) 3 days					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1-15 19 56, to 1-18 19 56, 1-10 P.M., from the causes and on the date stated above. alive on 1-18 19 56, and that death occurred at 1-10 P.M., from the causes and on the date stated above. ADDRESS (Street, city, town, state) M.D. USNH, Bainbridge, Maryland DATE SIGNED 1-19-56 SIGNATURE <i>Jill H. T. Mc USA</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal & Burial		DATE THEREOF 1-19-56		NAME OF CEMETERY OR CREMATORIAL Benham Cemetery	
24. REC'D BY REGISTRAR DATE 1-18-56		REGISTRAR'S SIGNATURE Dorothy B. Bramble		LOCATION (City, town, or county) Benham, Indiana ADDRESS Perryville, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. T. Mc USA</i>					

MANUFACTURED OR IMPORTED TO HAWAII - CALIFORNIA

CERTIFICATE OF DEATH

BUREAU OF  
LEGEND

JAN 25 1958

## INSTRUCTIONS

1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00463

482

## CERTIFICATE OF DEATH

Reg. Dist. No. 4C

## 1. PLACE OF DEATH

COUNTY

Cecil

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

LENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSPort Deposit Life  
Rock Run

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Md

COUNTY

Cecil

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

STREET  
ADDRESSPort Deposit  
(If rural, give location)

Rock Run

3. NAME OF  
DECEASED  
(Type or Print)

(First)

George

(Middle)

(Last)

Body

4. DATE  
OF  
DEATH

JAN - 19 56

(Month) (Day) (Year)

5. SEX

Male

6. COLOR OR  
RACE

Col-

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Widowed

8. DATE OF BIRTH

Nov - 28 1868

9. AGE last birthday

87 yrs.

10. IF UNDER 1 YEAR  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)10b. KIND OF BUSINESS  
OR INDUSTRY

10c. BIRTHPLACE (State or foreign country)

10d. CITIZEN OF WHAT  
COUNTRY

GENERAL

Md

## 13. FATHER'S NAME

Rev. George J. Body

## 14. MOTHER'S MAIDEN NAME

Nancy C. Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, No, or unk.)

(If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

18. MEDICAL CERTIFICATION

19. IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST, DUE TO

(C)

20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH21. DISEASE OR CONDITIONS  
CONTRIBUTING TO THE DEATH  
DUE TO

22. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

23a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21c. WHERE DID INJURY OCCUR? (City or town)  
(County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
M. at work  Not while  
at work  at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

alive on Jan 19 1956

and that death occurred at 9A.M. from the causes and on the date stated above.

Signature

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

24. REC'D BY REGISTRAR

DATE

1-22-1956

Diane E. Daugherty

482

DATE THEREOF

1-21-1956

Mt. Joaquin

NAME OF CEMETERY OR CREMATORIAL

Conowingo, Md

LOCATION (City, town, or county)

(State)

482

ADDRESS

482

Lee A. Patterson &amp; Son, Perryville

Md

NAME OF CEMETERY OR CREMATORIAL

Conowingo, Md

LOCATION (City, town, or county)

(State)

482

ADDRESS

482

Lee A. Patterson &amp; Son, Perryville

Md

4 122

467

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place) 1 day	STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Elkton, Md.	COUNTY Cecil (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Union Hospital	STREET ADDRESS	
3. NAME OF DECEASED (First) (Type or Print)	(Middle)	(Last)	4. DATE (Month) OF DEATH: 1 (Day) 24 (Year) 1956
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: Sept. 23, 1956
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday IF UNDER 1 YEAR yrs. 4 Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: William T. Brinkley		14. MOTHER'S MAIDEN NAME: Flossie Murdock	
15. WAS DECEASED EVER IN U.S. ARMEO FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): No		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: William T. Brinkley		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
IMMEDIATE CAUSE (A) DUE TO Pertussis			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 19, 1956, to Jan. 24, 1956, that I last saw the deceased alive on Jan. 23, 1956, and that death occurred at 7:15 A.M. from the causes and on the date stated above. SIGNATURE: S. Ralph Anderson, Jr.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: 1/26/56	
NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county) (State): Elkton, Maryland	
DATE REC'D BY LOCAL REGISTRAR: Jan 26		REGISTRAR'S SIGNATURE: H. Fraser	
24. FUNERAL DIRECTOR:		ADDRESS: H. Waller Jr. Elkton, Md.	

or

483

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

COUNTY Cecil MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN Perry Point 4 yrs. 19 days

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS Veterans Administration Hospital

3. NAME OF  
DECEASED:  
(Type or Print)WILLIAM

(Middle)

(Last)

## 4. SEX:

Male5. COLOR OR  
RACE:NegroTOA. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):Farmer10B. KIND OF BUSINESS  
OR INDUSTRY:self-employed

## 13. FATHER'S NAME:

JESSE CARRINGTON15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service) Yes WW-I

## 16. SOCIAL SECURITY NO.

Unknown

## 17. INFORMANT &amp; ADDRESS:

Hospital Records, VAH., Perry Point, Md.18. MEDICAL CERTIFICATION  
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATHINTERVAL BETWEEN  
ONSET AND DEATH

## IMMEDIATE CAUSE

Auricular fibrillation

1 hr.

DUE TO

## ANTECEDENT CAUSE (\$)

Cardiac arrest

15-20 min.

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

DUE TO

Lobectomy, left upper lobe

2 hrs.

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

Tuberculosis pulmonary

unknown

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M. While  Not while   
at work  at work 

22. I hereby certify that I attended the deceased from Jan. 8, 1952, to Jan. 27, 1956, the

and that death occurred at 2:43 PM, from the causes and on the date stated above.  
ADDRESS

DATE SIGNED

SIGNATURE W. Oppler, M.D. Director, Professional Services, VAH., Perry Point, Md.

1-29-56

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
REMOVAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

1-29-56

Unknown

Virginia

DATE REC'D BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-24-56

Gene E. DoughertyLongington + Son

eGrace, Md.

FENNINGTON &amp; SON, FAYRE D.

BUREAU Y. S.

FEB 1 19

RECEIVED

484

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH.

COUNTY **Cecil** MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 X TOWN **Perry Point** 26 yrs. 4 mo. 13 days  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS **Veterans Administration Hospital**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN **Baltimore**  
 STREET ADDRESS (If rural give location)  
**617 Grantley**

3. NAME OF (First) (Middle) (Last)  
 DECEASED: (Type or Print) **GEORGE W. COOK**

4. DATE (Month) (Day) (Year)  
 OF DEATH: **January 10 1956**

5. SEX 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE OF BIRTH:  
 RACE: WIDOWED, DIVORCED, (Specify): **Male White Single 8-18-93**

9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.  
**62 yrs.**

10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS  
 work done during most of working life, OR INDUSTRY:  
 even if retired): **Brakeman Penna. Railroad**

11. BIRTHPLACE (State or foreign country): **Maryland** 12. CITIZEN OF WHAT  
 COUNTRY? **USA**

13. FATHER'S NAME:

**Joseph Cook**

14. MOTHER'S MAIDEN NAME:

**Isabella Griffith**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.  
 (Yes, no, or unk.) (If Yes, give war or dates  
 of service) **Yes** **W.W.I** **unknown**

17. INFORMANT & ADDRESS:  
**Hospital Records, VAH, Perry Point, Md.**

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
 ONSET AND DEATH

**002 X**

IMMEDIATE CAUSE

**Tuberculosis of the lungs bilateral, with**

unknown

ANTECEDENT CAUSE (S)

(A) DUE TO **chronic adherent pleurisy, left**

unknown

DISEASES OR CONDITIONS, IF ANY,  
 GIVING RISE TO THE ABOVE CAUSE  
 STATING UNDERLYING CAUSE LAST.

(B) DUE TO **Coronary arteriosclerosis, moderately**

severe

(C) **Cirrhosis of the liver**

unknown

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
 TO THE DEATH BUT NOT RELATED TO THE  
 DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
 (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory,  
 OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)  
 INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
 OF INJURY

21E. INJURY OCCURRED  
 While  Not while   
 at work  at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that **X** attended the deceased from **8-28, 1929, to 1-10, 1956**, **and that death occurred at 6:30a M.**, from the causes and on the date stated above.

**Signature: J.C. Grasberger** **Services ADDRESS DATE SIGNED**  
**J.C. Grasberger, Acting Director, Professional M. D. V.A. Hospital, Perry Point, Md. 1-12-56**

23. BURIAL, CREMATION,  
 REMOVAL (SPECIFY)  
**Removal**

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county) (State)

**1-12-56**

**Baltimore National**

**Baltimore, Md.**

DATE REC'D BY LOCAL  
 REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

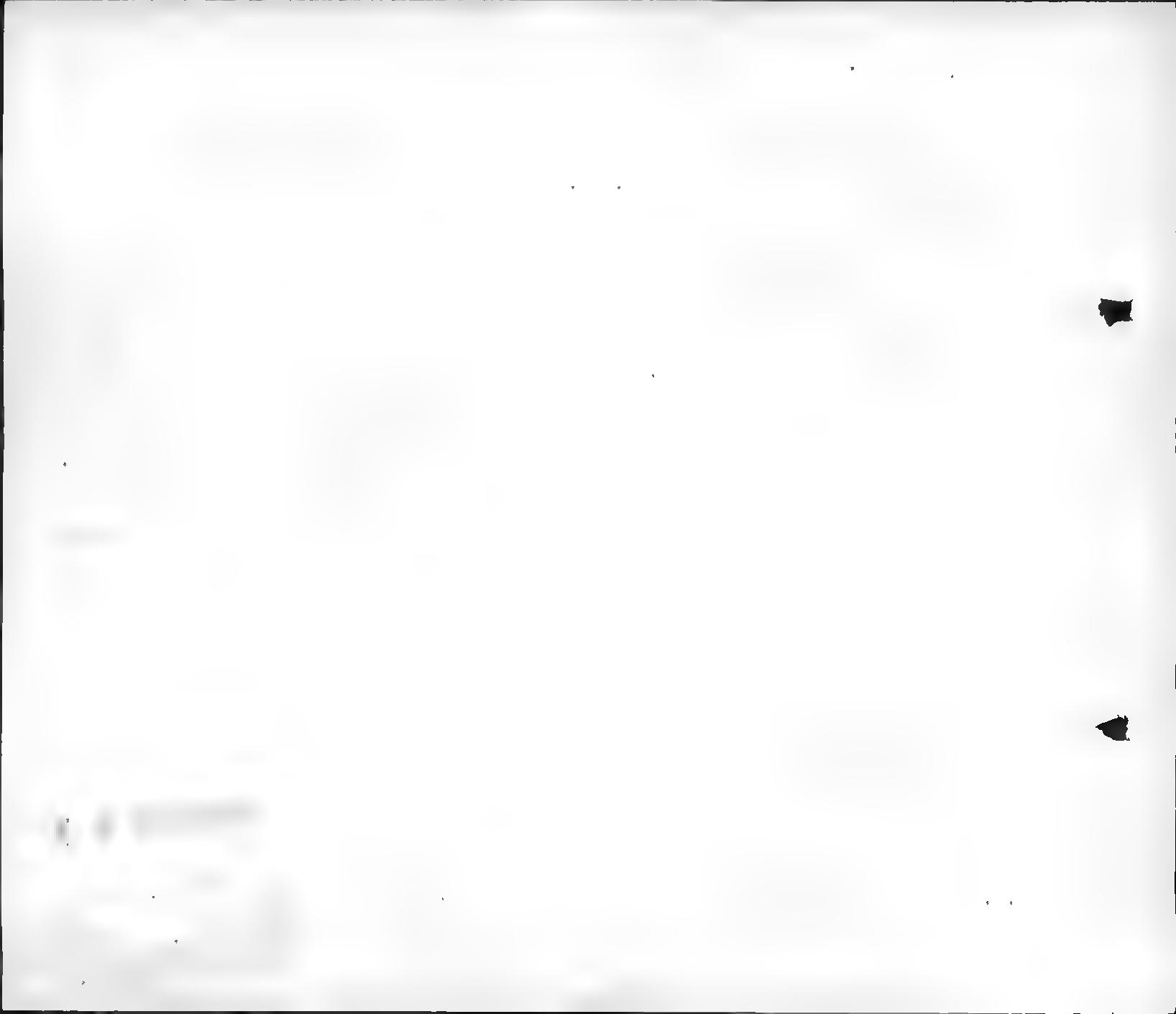
ADDRESS

**1-12-56**

**Irene E. Dougherty**

**Pennington & Sons, de Gracie, Md.**

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The  
 correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00467

468

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Elkton</u>	
LENGTH OF STAY (in this place) <u>30 yrs.</u>		STREET ADDRESS <u>212 W. Main Street</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		(If rural give location)	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>Howard</u> (Last) <u>Davis</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>Jan. 17</u> <u>1956</u>	
5. SEX: <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Married</u>		8. DATE OF BIRTH: <u>June 14-1866</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9. AGE last birthday <u>89</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): <u>Carroll County Md.</u>	
13. FATHER'S NAME: <u>James Thomas Davis</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs Russell George daughter Elkton Md</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>General Arteriosclerosis</u> ANTECEDENT CAUSE (B) <u></u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Elkton</u>	
21C. WHERE DID INJURY OCCUR? (City or town) <u>Elkton</u> (County) <u>Maryland</u> (State) <u>Md.</u>		21D. TIME (Month) (Day) (Year) OF INJURY <u>Jan. 25</u> <u>1956</u>	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? M.D. <u>Cherry Hill Cemetery</u>	
22. I hereby certify that I attended the deceased from <u>Jan 25</u> , 1956, to <u>Jan 17</u> , 1956 that I last saw the deceased alive on <u>Jan 17</u> , 1956 and that death occurred at <u>3:05 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>H. M. Frazer</u> ADDRESS <u>Elkton, Maryland</u> DATE SIGNED <u>Jan 18-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-21-56</u> NAME OF CEMETERY OR CREMATORIAL <u>Cherry Hill Cemetery</u> LOCATION (City, town, or county) <u>Cherry Hill</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 21</u>		REGISTRAR'S SIGNATURE <u>H. Frazer</u> 24. FUNERAL DIRECTOR ADDRESS <u>Pippin Funeral Home</u> <u>Elkton, Md.</u>	

1700

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ....

## 1. PLACE OF DEATH:

COUNTY

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(or this place)

TOWN Coronado, Calif.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md. COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWN Coronado, Calif.STREET  
ADDRESS

(If rural, give location)

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

4. DATE  
OF  
DEATH

1 16 1956

(Month) (Day) (Year)

5. SEX:

F.

6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR  
MonthsIF UNDER 24 HRS.  
Days Hours Min.

65 yrs.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even part time)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY

## 13. FATHER'S NAME:

Jarris Jones

## 14. MOTHER'S MAIDEN NAME:

Bethana Philippe

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS:  
Elonzo Davis Coronado, Md.

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1  
Immediate cause

(a) DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, (b) DUE TO  
giving rise to the above cause  
stating underlying cause last (c)

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATHII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?  
Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY)

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY M.21e. INJURY OCCURRED  
While at Not while  
work  at work 

21f. HOW DID INJURY OCCUR?

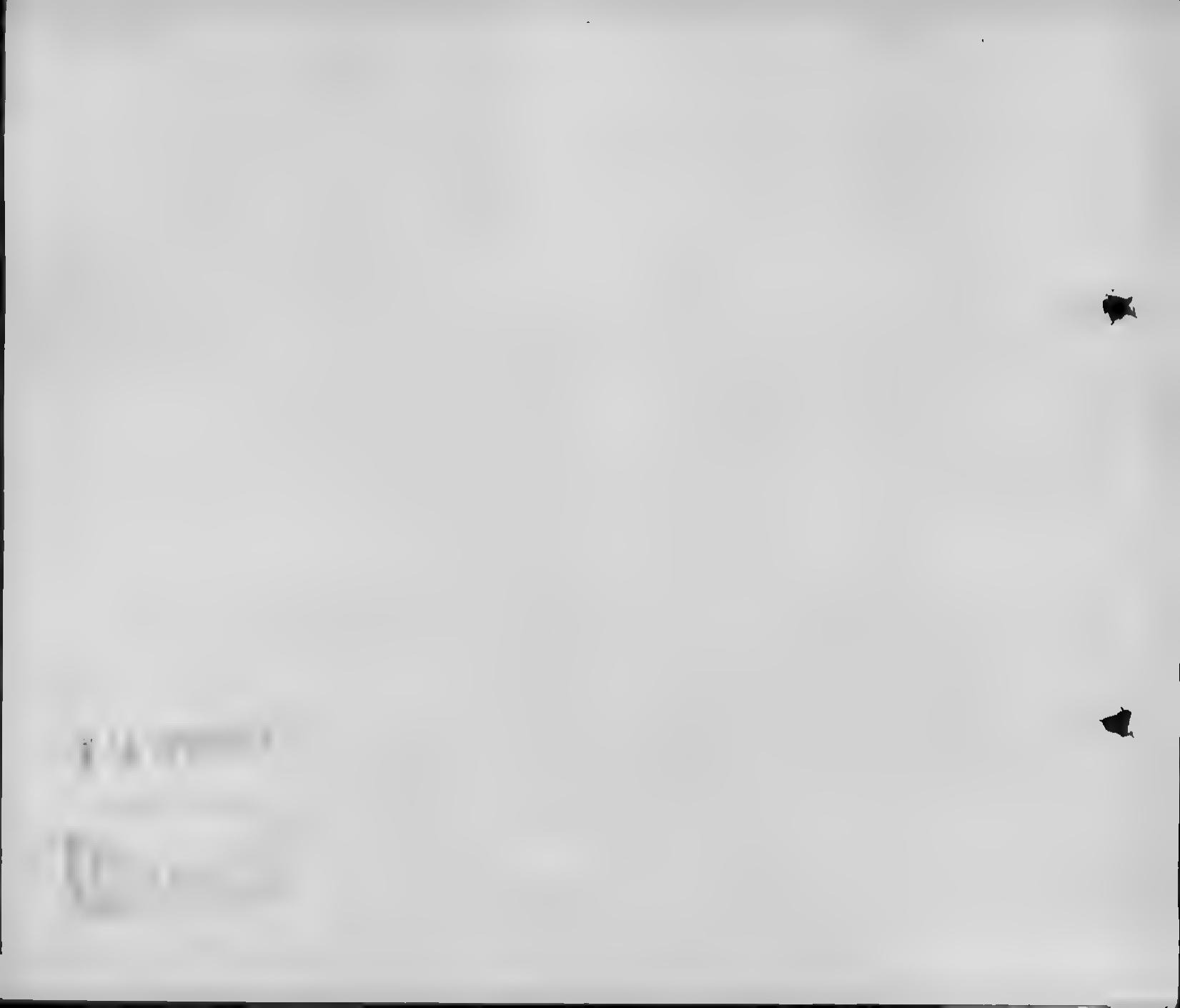
22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and  
find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .  
SIGNATURE *DeWolfe*CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAM.DATE SIGNED  
1-17-5623. BURIAL, CREMATION,  
REMOVAL (Specify):DATE REC'D. BY LOCAL  
REG.

DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Jan 19 1956 Coronado Baptist Church Coronado Calif. Md.

REG. No. 17-16777

REG. No. 17-167



486

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Cecil	MARYLAND	STATE Maryland COUNTY Harford
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Length of Stay (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Perryville	1 month 2 days	TOWN	Cardiff
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Adm. Hospital		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print)	(First) Paul	(Middle) R.	(Last) Donnan
4. DATE (Month) OF DEATH: Jan. 13,	(Day) 1956	(Year)	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single	8. DATE OF BIRTH: 4-27-89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager		10B. KIND OF BUSINESS OR INDUSTRY: Theater	9. AGE last birthday 66 IF UNDER 1 YEAR yrs. Months Days Hours Min.
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: James A. Donnan		14. MOTHER'S MAIDEN NAME: Elizabeth Lane	
15. SOCIAL SECURITY NO. 215 16 0416		16. INFORMANT & ADDRESS: Hospital Records	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
260X IMMEDIATE CAUSE (A) Arteriolar nephrosclerosis. 4 years DUE TO			
ANTECEDENT CAUSE (S) (B) Diabetes Mellitus. 5 years DUE TO			
(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 1/14/56	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 12/11/1955, to 1/13/1955, <del>He was sawed to pieces</del> and <del>He was sawed to pieces</del> and that death occurred at 10:55PM, from the causes and on the date stated above. SIGNATURE: <i>W. H. Harkins</i> DATE SIGNED			
23. BURIAL/CREMATION REMOVAL (SPECIFY) Removal		DATE THEREOF 1-14-56	NAME OF CEMETERY OR CREMATORIAL Slate Ridge
DATE REC'D BY LOCAL REGISTRAR 1-14-56		24. FUNERAL DIRECTOR H. Harkins, Delta, Pa.	ADDRESS 1/14/56
REGISTRAR'S SIGNATURE Irene E. Daugherty			

BUREAU # 2

JAN 17 1956

DECEIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 92

## 1. PLACE OF DEATH:

COUNTY

Cecil

MARYLAND

CITY (If outside corporate limits write RURAL  
OR and give nearest town)  
TOWN

Clinton

LENGTH OF STAY  
in this placeHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Union St. D.O.A.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

Cecil

CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWN

Elk Mills

(If rural, give location)

STREET  
ADDRESS3. NAME OF  
DECEASED:  
(Type or Print)

(First) (Middle) (Last)

4. DATE  
OF  
DEATH

(Month) (Day) (Year)

## 5. SEX

M.

6. COLOR OR  
RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify)

Single

## 8. DATE OF BIRTH:

Aug 14 1950

## 9. AGE last birthday:

1 yrs.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired)

Manufact

10b. KIND OF BUSINESS OR  
INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

Elkton Md.

12. CITIZEN OF WHAT  
COUNTRY

USA

## 13. FATHER'S NAME:

Richard Harmon Dore, Jr.

## 14. MOTHER'S MAIDEN NAME:

Besie Goraker

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of  
service)

no

## 16. SOCIAL SECURITY NO.:

—

## 17. INFORMANT &amp; ADDRESS:

Richard H. Dore, Jr. Elk Mills

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

085.1

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any.

(b) DUE TO

giving rise to the above cause

stating underlying cause last

(c)

Bronchitis Pneumonia

3 day measles.

INTERVAL BETWEEN  
ONSET AND DEATHII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY

## 21c. (City or town) (County)

## (State)

## 21d. TIME (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
OF  
INJURY

M.

While at work Not while at work 

## 21f. HOW DID INJURY OCCUR?

BUREAU V

NO 17 1200

REGALIVE

## INSTRUCTIONS

1

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS. AISC 155-10W

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

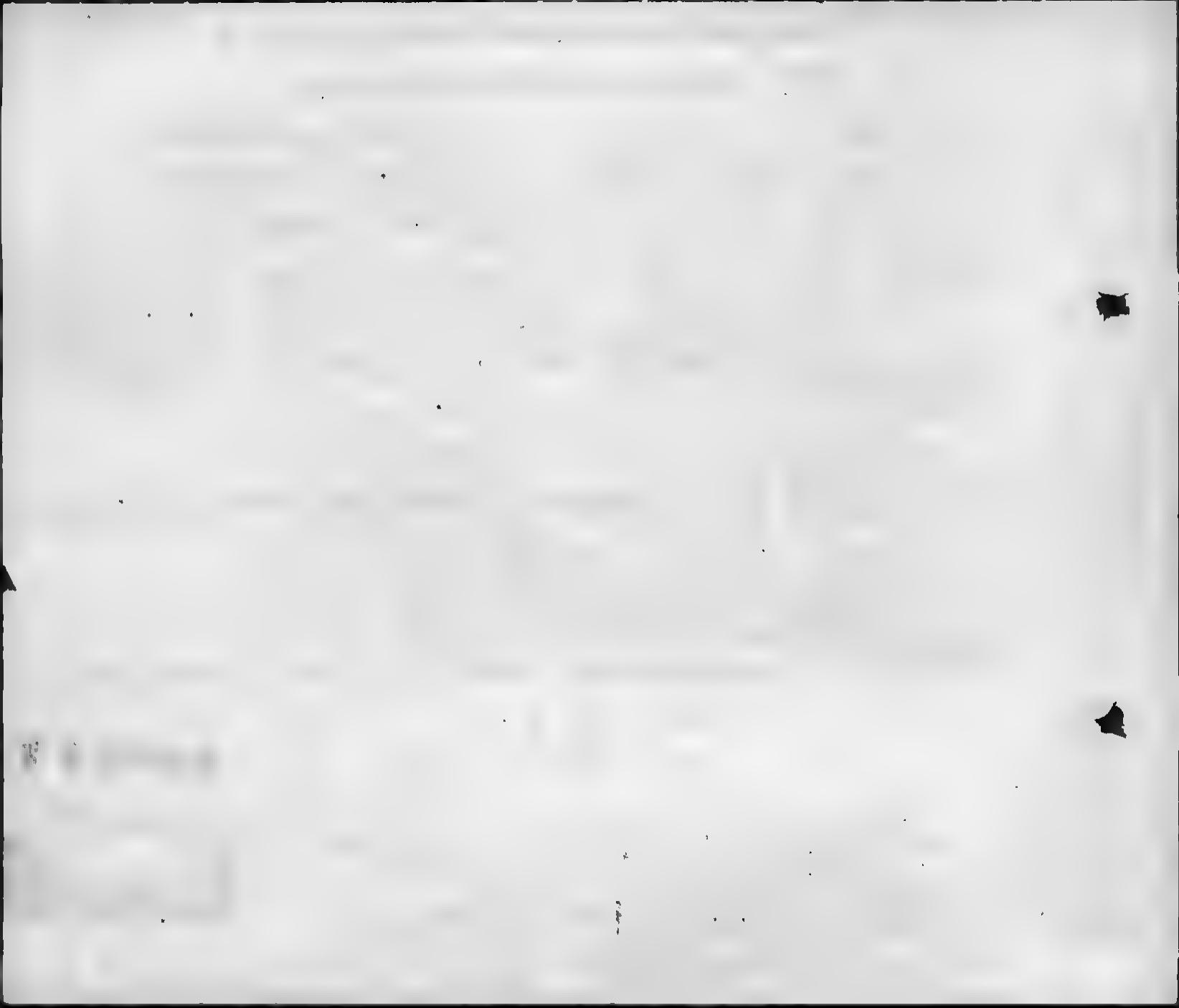
00471

470

## CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Cecil Elkton	MARYLAND LENGTH OF STAY (in this place)	STATE MD. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Life		STREET ADDRESS
Union Hospital		Rural Earleville	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Harry Duff		Jan. 4 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 9, 1896
9. AGE last birthday 59 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Md.	
Farm Labor		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Duff		14. MOTHER'S MAIDEN NAME Margaret J. Culley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 215 32 1633	
17. INFORMANT & ADDRESS Thomas Duff Earleville Md.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH 7 min 7 min year. 4 days.	
Coronary Occlusion Atherosclerotic Heart Disease Pulmonary Embolism			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 6</u> , 19 <u>55</u> , to <u>Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 4 1956</u> , 19 <u>56</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Wallace Ohnscheid</u> M.D. ADDRESS (Street, city, town, state) <u>Cecilton Md.</u> DATE SIGNED <u>Jan. 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 7. 1955 NAME OF CEMETERY OR CREMATORIUM Cecilton Cemetery	
24. REC'D BY REGISTRAR DATE <u>1/6/56</u>		REGISTRAR'S SIGNATURE <u>Edward Fellows</u> ADDRESS	
		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u> ADDRESS <u>Edward Fellows Millington Md.</u>	



487

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:  COUNTY CECIL MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN PERRY POINT, MD.		2. USUAL RESIDENCE (HOME) OF DECEASED.  STATE PEN. SYLVANIA COUNTY ALLEGHENY CITY (If outside corporate limits, write RURAL and give nearest town) TOWN PITTSBURGH STREET ADDRESS 438 Cadet Avenue	
3. NAME OF DECEASED: (First) JOSEPH J. FLEISNER (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH: January 14 1956	
5. SEX: M 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Divorced		8. DATE OF BIRTH: March 20, 1896	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk.		10B. KIND OF BUSINESS OR INDUSTRY: Unk	
13. FATHER'S NAME: AUTHOR FLEISNER		11. BIRTHPLACE (State or foreign country): Penna.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkn.) Yes (If Yes, give war or dates of service) WW-I		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. None		14. MOTHER'S MAIDEN NAME: UNKNOWN	
17. INFORMANT & ADDRESS: Hospital Records, VAH., Perry Point, Md.			
18. MEDICAL CERTIFICATION  I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  IMMEDIATE CAUSE (A) Bronchopneumonia, unresolved, left lower lobe. DUE TO Arteriosclerosis with narrowing of coronary artery.  ANTECEDENT CAUSE (B) DUE TO Arteriosclerosis, general.  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  (C) DUE TO			
INTERVAL BETWEEN ONSET AND DEATH 3 5 days Unknown Unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 7, 1956, to Jan. 14, 1956, at Perry Point, Md., and that death occurred at 4:05 A.M. from the causes and on the date stated above. SIGNATURE: <i>J. C. Fleisner</i> ADDRESS: <i>Acting Director Professional Services, VAH., Perry Point, Md.</i> DATE SIGNED: <i>1/15/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		DATE THEREOF NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county) (State) 1-15-56 Unknown Unknown Pittsburgh Pa.	
DATE REC'D BY LOCAL REGISTRAR 1-16-56		24. FUNERAL DIRECTOR ADDRESS REGISTRAR Dame E. Daugherty	
PENNINGTON & SON, Havre DeGrace, Md.		Dame E. Daugherty	

3.8.1

3.8.2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 9, Form 11-16-56, 61  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 94

## 1. PLACE OF DEATH:

COUNTY

Cecil

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(If rural, give weeks)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Silvers Laundry.

3. NAME OF  
DECEASED:  
(Type or Print)

ERNEST

(Middle)

(Last)

HART

4. DATE  
OF  
DEATH1  
8

1966

(Month)  
(Day)  
(Year)

## 5. SEX:

M

6. COLOR OR  
HAIR:

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED:

Single

## 8. DATE OF BIRTH:

1906

## 9. AGE last birthday:

49

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if not at time of death):

Laborer

10b. KIND OF BUSINESS OR  
INDUSTRY:

Canning

## 11. BIRTHPLACE (State or foreign country):

Kentucky

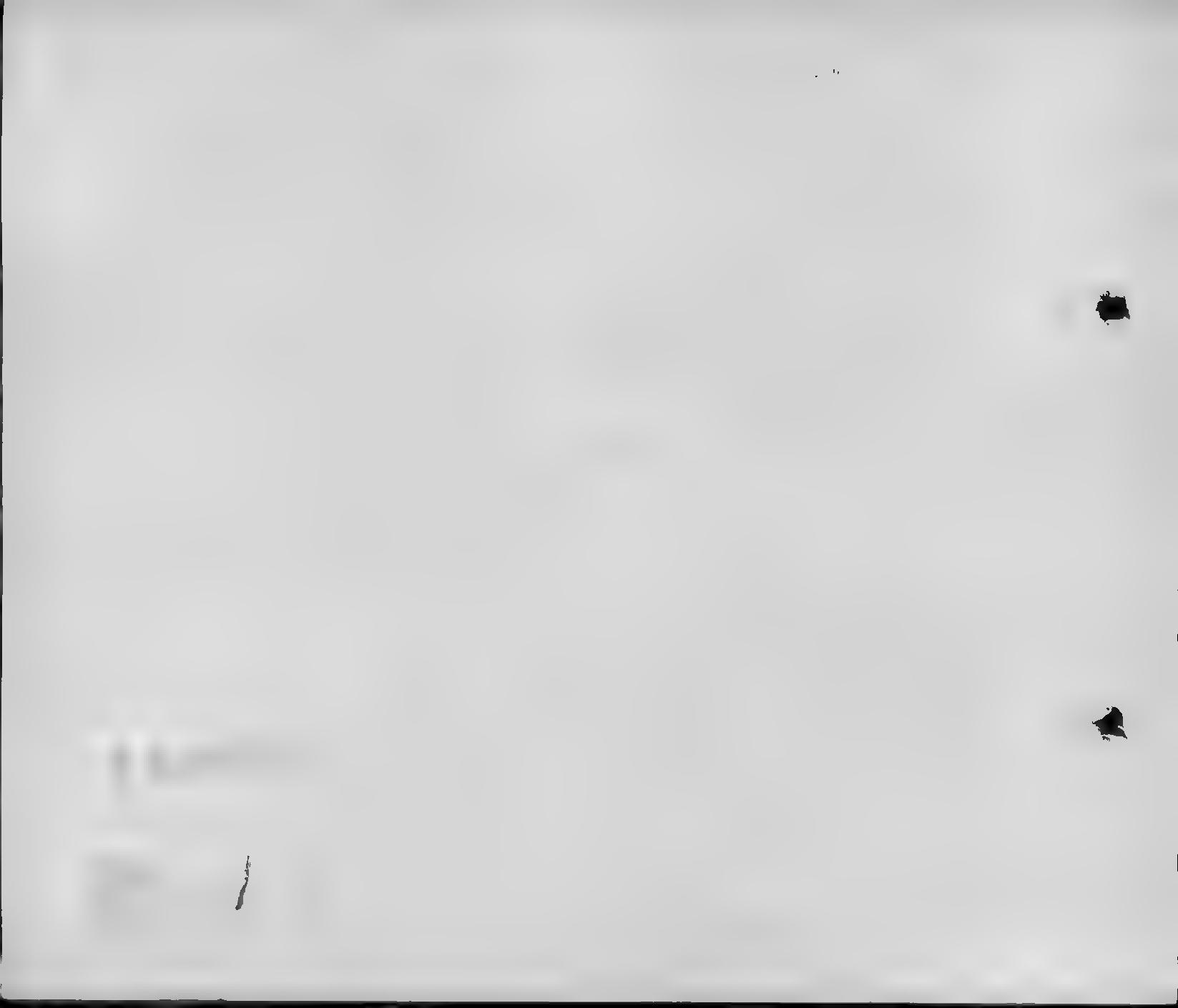
12. CITIZEN OF WHAT  
COUNTRY?

USA

## 13. FATHER'S NAME:

John

Hart





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## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

COUNTY **Cecil** MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (in this place)  
 TOWN **Ferry Point** 9 days

HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS **Veterans Administration Hospital**

3. NAME OF DECEASED: (First) (Middle) (Last)  
 (Type or Print) **GEORGE N. HILL**

5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE OF BIRTH  
 RACE: WIDOWED, DIVORCED  
 (Specify): **Male Negro Married** **10-4-98**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **Laborer**

10B. KIND OF BUSINESS OR INDUSTRY: **Unknown**

4. DATE (Month) (Day) (Year)  
 OF DEATH: **January 5 1956**

9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

**57 yrs.**

## 13. FATHER'S NAME:

**George Hill - Deceased**

## 11. BIRTHPLACE (State or foreign country):

**Washington, D. C.**

12. CITIZEN OF WHAT COUNTRY?  
**USA**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.  
 (Yes, no, or unk.) (If Yes, give war or dates of service) **Yes** **WW I** **Unknown**

## 14. MOTHER'S MAIDEN NAME:

**Estelle Stewart - Deceased**

## 17. INFORMANT &amp; ADDRESS:

**Hospital Records, VAH, Perry Point, Md.**

18. MEDICAL CERTIFICATION  
 I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
 ONSET AND DEATH

## IMMEDIATE CAUSE

(A) **Hemorrhage inter abdominal**

1 day

## ANTECEDENT CAUSE (#)

(B) **Cirrhosis of the liver**

Approx.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

2 yrs.

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO

21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH **IF EITHER, NOTIFY MEDICAL EXAMINER** 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21C. WHERE DID (City or town) (County) (State)  
 INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR?

OF INJURY **VA M.** While  Not while   
 at work  at work

22. I hereby certify that I attended the deceased from **12-27, 1955, to 1-5-1956**, and that death occurred at 5:00 AM, from the causes and on the date stated above.  
 ADDRESS **12-27, 1955, to 1-5-1956** DATE SIGNED  
 SIGNATURE **W. OPPLER**

W. OPPLER, Director, Professional Services, M. D. VAH, Perry Point, Md.

**1-5-56**

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)  
 REMOVAL **1-5-56** **Arlington National Cemetery** **Arlington, Va.**

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS  
 REGISTRAR **1-5-56** **Isaac E. Slawny** Hoffman's Fun. Home, 611 K. St., N.W. Wash. D.C.

## SAFETY

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## CERTIFICATE OF DEATH

Reg. Dist. No. 92

Item 8, FilmG192 2-1-56 et

## 1. PLACE OF DEATH:

COUNTY CECIL MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR and give nearest town  
 TOWN ELKTON LENGTH OF STAY  
 (in this place)  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS  
Union Hospital.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY CECIL  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR and give nearest town  
 TOWN ELKTON 21  
 STREET ADDRESS  
 (If rural give location)  
202 Blue Ball St.

3. NAME OF  
 DECEASED:  
 (First) ANNIE (Middle) V. (Last) HOLMES

4. DATE  
 (Month) 1 (Day) 22 (Year) 1956

5. SEX: F 6. COLOR OR  
 RACE: W 7. SINGLE, MARRIED,  
 WIDOWED, DIVORCED.  
 (Specify): MAR.8. DATE OF BIRTH 1881

Nov. 10, 1888

9. AGE last birthday:  
 If UNDER 1 YEAR  
 yrs. Months Days Hours Min.

If UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of  
 work done during most of working life,  
 even if retired): Housewife10b. KIND OF BUSINESS OR  
 INDUSTRY: —11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.12. CITIZEN OF WHAT  
 COUNTRY? U.S.13. FATHER'S NAME: JAMES MCDONALD14. MOTHER'S MAIDEN NAME: —15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (Yes, no, or unk.) (If Yes, give war or dates of  
 service) No16. SOCIAL SECURITY NO.: —17. INFORMANT & ADDRESS: Mrs. ESTER RITTENHOUSE, Elkton18. MEDICAL CERTIFICATION  
 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) MASSIVE CEREBRAL HEMORRHAGE 2 days.  
 DUE TO —

## Antecedent causes (s)

(b) CVA 2 days.  
 DUE TO —

Diseases or conditions, if any,  
 giving rise to the above cause  
 stating the underlying cause last.

(c) CEREBRAL VASCULAR SCLEROSIS 5-6 yrs.  
 DUE TO —

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
 related to the disease or condition causing death.

DIABETES MELLITUS 26 yrs.?

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  Yes  No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

TIME (Month) OF INJURY	(Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
m.			

22. I hereby certify that I attended the deceased from 1/17/1956, to 1/22/1956, that I last saw the deceased

alive on 1/22/1956, and that death occurred at 8 A.M., from the causes and on the date stated above.  
 SIGNATURE John Shantz (Degree or title) M.D. ADDRESS Elkton Md. DATE SIGNED 1/22/56

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Jan 24 1956</u>	<u>Friends</u>	<u>Calvert, Cecil</u>	<u>Md</u>

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
<u>Jan 23</u>	<u>H. Frazer</u>	<u>Joseph A. Shantz</u>	<u>North East, Md</u>

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use in burial or transit permit.

VS AISC 155 10W

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00477

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

473

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Cecil CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Elkton		MARYLAND LENGTH OF STAY (In this place) 70 Yrs	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 404 North St.		STATE Md. COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkton STREET ADDRESS (If rural give location) 404 North St.	
3. NAME OF		4. DATE (Month) (Day) (Year)	
(First) Julia (Middle) A (Last) Juergens		OF DEATH JAN 1 1956	
5. SEX F	6. COLOR OR RACE WH	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH Aug. 15, 1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY House wife	11. BIRTHPLACE (State or foreign country) Ireland
13. FATHER'S NAME Benard Pryer		14. MOTHER'S MAIDEN NAME Susan Mulvaney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Mrs Emma Kincaid Elkton, Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442X IMMEDIATE CAUSE (A) Pulmonary edema ANTECEDENT CAUSE(S) DUE TO (B) Cardiac vascular canal DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) STATING UNDERLYING CAUSE LAST.			
INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 1955, to....., 1956, that I last saw the deceased alive on....., 1955, and that death occurred at....., 1956, from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
Herbert Bates		M.D. Elkton Md.	
DATE SIGNED 1/3/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan 4/56	
NAME OF CEMETERY OR CREMATORIAL Catholic		LOCATION (City, town, or county) Elkton Md.	
24. REC'D. BY REGISTRAR JAN 5 1956		REGISTRAR'S SIGNATURE Z. Rodney Freges	
DATE		25. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home Elkton, Md.	
		ADDRESS By W. Henry Pippin	

BUFILE V.4  
SEARCHED  
JAN 5 1985

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00478

490

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Cecil</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Cecil</i>	
CITY (if outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town)		TOWN <i>Port Deposit</i>	
TOWN <i>Port Deposit</i>		<i>life</i>		STREET ADDRESS		<i>Port Deposit</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Main St</i>		<i>Main St</i>		<i>Main St</i>		<i>If rural give location</i>	
3. NAME OF DECEASED (Type or Print) <i>Blanche</i>				4. DATE OF DEATH <i>Jan. 29 1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>April 8, 1879</i>	9. AGE last birthday 76	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. (Year) Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Abraham Hasson</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Kelly</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Joseph Mitchell, Port Deposit, Md</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>331X</i> IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i> 3 days ANTECEDENT CAUSE(S) DUE TO <i>Arterio-Sclerosis</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>Arterio-Sclerosis</i> 10 yrs GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arterio-Sclerosis</i> 12 yrs							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Arterio-Sclerosis</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan. 28, 1956</i> to <i>Jan. 29, 1956</i> , that I last saw the deceased alive on <i>Jan. 28, 1956</i> , and that death occurred at <i>10:30 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>E. Patterson</i> M.D. ADDRESS (Street, city, town, state) <i>Port Deposit, Md.</i> DATE SIGNED <i>1/30/56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-31-1956</i>		NAME OF CEMETERY OR CREMATORIAL <i>West Nottingham</i>		LOCATION (City, town, or county) <i>Colona, Md</i> (State)	
24. REC'D BY REGISTRAR DATE <i>1-31-1956</i>		REGISTRAR'S SIGNATURE <i>Irene E. Daugherty</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Irene E. Daugherty</i>		ADDRESS <i>Leila Patterson &amp; Son, Pergsville, Md</i>	



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate may be filed with the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be completely filled in by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00479

491

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
CITY OR TOWN		MARYLAND	STATE OR TOWN		COUNTY
Port Deposit		70 yrs	Port Deposit		Cecil
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
83 North Main St.			83 North Main		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
Chester Arthur Krauss			Jan. 2 1956		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE less birthday	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
Male	White	Married	July 25, 1880	75	Yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
Track Foreman			P.R.R.		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Penns.			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Stephen R. Krauss			Anna Barr		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unk.)			16. SOCIAL SECURITY NO.		
No unk.			218-05-6165		
17. INFORMANT & ADDRESS			18. MEDICAL CERTIFICATION		
Chester A. Krauss Jr. Port Deposit			Myocarditis		
19a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (A)			1 yrs.		
ANTECEDENT CAUSE(S) DUE TO					
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			Arterio - Sclerous 5 yrs.		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
M.			21e. INJURY OCCURRED While Not while at work at work		
21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Jan. 14 1955, to Dec. 31 1955, that I last saw the deceased alive on Dec. 31 1955, and that death occurred at 9 A.M. from the causes and on the date stated above. SIGNATURE <i>B. Patterson</i> M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			DATE THEREOF 1-5-1956		
NAME OF CEMETERY OR CREMATORIAL Hopewell			LOCATION (City, town, or county) Port Deposit, Md. Rural		
24. REC'D BY REGISTRAR DATE 1-5-1955			REGISTRAR'S SIGNATURE Irene E. Daugherty		
			25. FUNERAL DIRECTOR'S SIGNATURE Lega Patterson & Son, Lengerville, Md.		

But, the first time the "Lobster"

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00480

492

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <b>Cecil</b> STATE <b>MARYLAND</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Md.</b> COUNTY <b>Cecil</b>	
CITY (If outside corporate limits, write RURAL OR <b>TOWN</b> and give nearest town) <b>Colora</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>TOWN</b> <b>Colora</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print)	(First) <b>Doctor</b>	(Middle) <b>Clark</b>	(Last) <b>Lucas</b>
4. DATE OF DEATH: <b>Jan. 31</b>	(Month)	(Day)	(Year) <b>1956</b>
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>September 15, 1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Gardener</b>	
11. BIRTHPLACE (State or foreign country): <b>Floyd, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME: <b>Jack Lucas</b>		14. MOTHER'S MAIDEN NAME: <b>Priscilla Artizer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-8643A</b>	
17. INFORMANT & ADDRESS: <b>Mrs. Carl M. Edmondson Delta, Pa.</b>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <b>420.1</b>		DUE TO <b>Coronary Thrombosis</b>	
ANTECEDENT CAUSE (S):		DUE TO <b>Coronary Sclerosis</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.) <b>OF INJURY</b>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>M.</b>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1952 to Jan 31, 1956</b> that I last saw the deceased alive on <b>1/29</b> , 1956, and that death occurred at <b>118</b> M, from the causes and on the date stated above. SIGNATURE <b>Carl M. Edmondson</b>		ADDRESS <b>212156</b> DATE SIGNED <b>2/2/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Feb. 3, 1956</b> NAME OF CEMETERY OR CREMATORIUM <b>Darlington Cem.</b> LOCATION (City, town, or county) <b>Darlington</b> (State) <b>Md.</b>	
DATE REC'D. BY LOCAL REGISTRAR <b>Feb 2 1956</b>		REGISTRAR'S SIGNATURE <b>Carl M. Edmondson</b> FUNERAL DIRECTOR <b>Carl Tyson/Rising Sun, Md.</b> ADDRESS	

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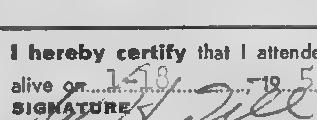
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DIRECTOR  
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00481

493

# **CERTIFICATE OF DEATH**

Reg. Dist. No.... 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED				
COUNTY <b>Cecil</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Rainbridge</b>		MARYLAND LENGTH OF STAY (In this place) <b>29 days</b>		STATE <b>Missouri</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Branson</b>		COUNTY <b>Taney</b> STREET ADDRESS <b>703 room Street</b> (If rural give location)		
3. NAME OF <b>ABEL</b> (Type or Print)				4. DATE (Month) (Day) (Year) <b>OP OF DEATH 1 18 19 56</b>				
S. SEX <b>Female</b>	6. COLOR OR RACE <b>Malayan</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>2-6-1</b>	9. AGE last birthday <b>37 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Marilao, Phillipine Island</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>ALBERTO DE LON</b>				14. MOTHER'S MAIDEN NAME <b>ALON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT & ADDRESS <b>navy Records</b>				
18. MEDICAL CERTIFICATION								
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>591 X IMMEDIATE CAUSE (A) UREMIA</b>								
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE <b>LEPHYLIS - CHLORIC</b>								
STATING UNDERLYING CAUSE LAST, DUE TO (C) HYPERTENSION - SEVERE								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12-20</b> , 19 <b>55</b> , to <b>1-12</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1-18</b> , 19 <b>56</b> , and that death occurred at <b>3:57 P.M.</b> from the causes and on the date stated above. SIGNATURE  <b>Dr. J. J. TILL, Jr. (C) M.D.</b> ADDRESS <b>U. S. NAVAL HOSPITAL, RAINBRIDGE, MD. 1-19-56</b>								
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal &amp; Burial</b>		DATE THEREOF <b>1-19-56</b>		NAME OF CEMETERY OR CREMATORIAL <b>Branson Cemetery</b>		LOCATION (City, town, or county) <b>Branson Missouri</b> (State)		
24. REC'D BY REGISTRAR <b>Dorothy B. Bramble</b>		REGISTRAR'S SIGNATURE <b>Dorothy B. Bramble</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W.A. Patterson &amp; Son, Perryville, Md.</b> ADDRESS				
DATE <b>1-19-56</b>								



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 94

## 1. PLACE OF DEATH:

COUNTY *Cecil* MARYLAND  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN *North East* LENGTH OF STAY  
 (in this place) *3 yrs.*  
 HOSPITAL OR  
 INSTITUTION OR  
 STREET ADDRESS *Beach & Main*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Md* COUNTY *Cecil*  
 CITY (If outside corporate limits write RURAL and give nearest town)  
 OR  
 TOWN *North East*  
 STREET ADDRESS *Beach & Main St.* (If rural, give location)

3. NAME OF  
DECEASED:  
(Type or Print)

(First) *DANIEL* (Middle) *BROSWORTH* (Last) *Mortz*

4. DATE  
OF  
DEATH *1 1 1956*

## 5. SEX:

M.

6. COLOR OR  
HAIR: *Dark*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify): *Married*

8. DATE OF BIRTH: *2-16-1901*

9. AGE last birthday: *54* IF UNDER 1 YEAR *0* IF UNDER 24 HRS.

Months *0* Days *0* Hours *0* Min. *0*

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life)  
ever *Painter*

10b. KIND OF BUSINESS OR  
INDUSTRY: *Ac Products*

11. BIRTHPLACE (State or foreign country): *Wabash Ind*

12. CITIZEN OF WHAT  
COUNTRY? *USA*

## 13. FATHER'S NAME:

*Mitchell Mortz*

## 14. MOTHER'S MAIDEN NAME:

*Mitchell Mortz*

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.)  (If Yes, give war or dates of  
service) *No*

16. SOCIAL SECURITY No.: *236-05-8471*

17. INFORMANT & ADDRESS: *Mrs Daniel B Mortz North East Md.*

18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause *(a)*  
DUE TO

Antecedent cause(s) *(b)*  
Diseases or conditions, if any, *(b)*  
giving rise to the above cause DUE TO  
stating underlying cause last *(c)*

2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN  
ONSET AND DEATH

21a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.

21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.)  
INJURY

21c. (City or town) *(County)* *(State)*

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY *M.* 21e. INJURY OCCURRED  
While at work  Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and  
find that death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined cause

SIGNATURE *Q. LeDodon* CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED *1-1-56*

23. BURIAL, CREMATION,  
REMOVAL (Specify): *Burial* DATE THEREOF *1-5-56* NAME OF CEMETERY OR CREMATORIAL *Gilpin Moral Cemetery* LOCATION (City, town, or county) *Reister* (State) *Md.*

DATE REC'D BY LOCAL REG. *1-3-1956* REGISTRAR'S SIGNATURE *Sarah E. Rothermel* 24. FUNERAL DIRECTOR *Joseph R. Grant, North East Md.* ADDRESS

18.00000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

495

**CERTIFICATE OF DEATH**

Reg. Dist. No. 96

LAESSE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:						
COUNTY		Cecil	STATE		(D. C. )				
CITY (If outside corporate limits, write RURAL OR and give nearest town)		MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY				
TOWN		Perry Point	LENGTH OF STAY (in this place)	TOWN		Washington			
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS						
Veterans Administration Hospital			(If rural give location)						
3. NAME OF DECEASED: (Type or Print)		(First) DANIEL	(Middle) L.	(Last) PATE	4. DATE (Month) (Day) (Year)				
5. SEX		6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married	8. DATE OF BIRTH	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
Male		White	5-3-76	9. AGE last birthday 79 yrs.	Months	Days Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard			10B. KIND OF BUSINESS OR INDUSTRY: Government -			11. BIRTHPLACE (State or foreign country): North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Andrews Field			14. MOTHER'S MAIDEN NAME: Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) Yes S.A.W.			16. SOCIAL SECURITY NO. 218 240 008			17. INFORMANT & ADDRESS: Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  X IMMEDIATE CAUSE (A) Thrombosis left anterior cerebral artery DUE TO ANTECEDENT CAUSE (S) (B) Arteriosclerosis, generalized and DISEASES OR CONDITIONS, IF ANY, STATING UNDERLYING CAUSE LAST. (C) cerebral, severe GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						3 to 4 days unknown			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.									
19A. DATE OF OPERATION: 2			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-9, 1951, to 1-9, 1956, and last saw the deceased  X, and that death occurred at 11:50aM, from the causes and on the date stated above. SIGNATURE W. Oppler W. OPPLER, Director, Professional Services M.D.						ADDRESS DATE SIGNED VAH, Perry Point, Md. 1-10-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			DATE THEREOF 1-10-56			NAME OF CEMETERY OR CREMATORIAL Arlington National		LOCATION (City, town, or county) Arlington, Va. (State)	
DATE REC'D BY LOCAL REGISTRAR			REGISTRAR'S SIGNATURE Irene E. Daugherty			24. FUNERAL DIRECTOR PENNINGTON & Son, Havre de Grace, Md.		ADDRESS	
11-56									



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 96

## 1. PLACE OF DEATH:

COUNTY

beril

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

LENGTH OF STAY

in this place

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSberowne's life  
Art Gale

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

beril

CITY (If outside corporate limits write RURAL and give nearest town)

TOWN

STREET  
ADDRESSberowne's  
Art Gale

(If rural, give location)

3. NAME OF  
DECEASED:  
(Type or Print)

(First) JOSEPH.

(Middle)

(Last) PETERS

DATE  
OF  
DEATH10  
(Month)  
10  
(Day)  
1956  
(Year)

## 5. SEX

6. COLOR OF  
FACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED10a. USUAL OCCUPATION (Give kind of  
work done during most of work life, even  
if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT  
COUNTRY

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT &amp; ADDRESS:

no

Bertha Brown, Port Deposit

Md

18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

445 X

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, (b)

giving rise to the above cause DUE TO

stating underlying cause last (c)

19. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes  No 

21a. EXTERNAL CAUSE WAS

PRIMARY  or CONTRIBUTING  CAUSE OF DEATH

21b. PLACE (Home, farm, factory,

OF street, office bldg., etc.)

INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)

OF INJURY

M.

21e. INJURY OCCURRED

While at work Not while at work 

21f. HOW DID INJURY OCCUR?

at work 

and

22. I hereby certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  andfind that death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined cause 

SIGNATURE

A. E. DODD, M.D.

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

1-16-56

23. BURIAL, CREMATION,  
REMOVAL (State):

Burial

DATE THEREOF

1-13-1956

NAME OF CEMETERY OR CEMETORY

Mt. Zion

LOCATION (City, town, or county)

Crownsville, Md

(State)

24. FUNERAL DIRECTOR

None

REG.

1-13-1956

REGISTRAR'S SIGNATURE

Done in the County of Perryville, Md

ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 27

## 1. PLACE OF DEATH:

COUNTY Cecil

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWNLENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS U. S. Naval Hospital3. NAME OF  
DECEASED:  
(Type or Print)

RICHARD

(First) (Middle)

(Last) PROPIS, JR.

4. SEX:  
Male6. COLOR OR  
RACE:  
White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): Single8. DATE OF BIRTH:  
11-16-554. DATE  
OF  
DEATH JUN. 2 1956

(Month) (Day) (Year)

9. AGE last birthday:  
IP UNDER 1 YEAR  
yrs. Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY:11. BIRTHPLACE (State or foreign country):  
Bainbridge, Maryland12. CITIZEN OF WHAT  
COUNTRY? U.S.A.

## 13. FATHER'S NAME:

Richard Buddy Lewis, Sr.

## 14. MOTHER'S MAIDEN NAME:

Geraldine GRIFFIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service):

16. SOCIAL SECURITY NO.: -----

17. INFORMANT & ADDRESS:  
Navy Records

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

O.S. /  
Immediate cause (a) BRONCHOPNEUMONIA IN A MALARIA CASE.  
DUE TOINTERVAL BETWEEN  
ONSET AND DEATH

## Antecedent cause(s)

Diseases or conditions, if any, (b)  
giving rise to the above cause DUE TO  
stating underlying cause last (c)2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?  
Yes  No   
(State)21a. EXTERNAL CAUSE WAS PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.)  
INJURY

21c. (City or town) (County)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY M. 21e. INJURY OCCURRED  
While at Not while  
work  at work  21f. HOW DID INJURY OCCUR?22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and  
find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .  
SIGNATURE *R. Woodson*CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAM.DATE SIGNED  
*1-3-56*23. BURIAL, CREMATION,  
REMOVAL (Specify) Remo. to Cremation DATE THEREOF 1-1-56 NAME OF CEMETERY OR CREMATORIAL CIL in Manor Cemetery LOCATION (City, town, or county) Elkton (State) Maryland

DATE REC'D BY LOCAL REG. 1-2-56 REGISTRAR'S SIGNATURE Dorothy B. Bramble Poppin Funeral Home Elkton, Md. 24. FUNERAL DIRECTOR ADDRESS

By D.B.B.

BUREAU W. S.

JAN 5 1970

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH 474 COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b> COUNTY <b>Cecil</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Elkton</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>E North East</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital-Elkton		STREET ADDRESS Elkton Cecil Avenue	
3. NAME OF DECEASED: (First) <b>Maude</b> (Middle) <b>Leedom</b> (Last) <b>Rose</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>Jan. 28, 1956</b>	
5. SEX: <b>Female</b> 6. COLOR OR RACE: <b>White</b> 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <b>Widow</b>		8. DATE OF BIRTH: <b>Oct 20, 1874</b> 9. AGE last birthday: <b>81</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY: <b>Home</b> 11. BIRTHPLACE (State or foreign country): <b>Bay View Cecil Co Md.</b> 12. CITIZEN OF WHAT COUNTRY: <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Edward T. Leedom</b>		14. MOTHER'S MAIDEN NAME: <b>Mary Tyson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> 16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <b>212-24-7535</b>		17. INFORMANT & ADDRESS: <b>Francis Rose North East, Md.</b>	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  IMMEDIATE CAUSE <b>Respiratory and Cardiac failure</b> ANTECEDENT CAUSE (S) (A) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO C (C) <b>Carcinoma of lungs</b>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Pleural effusion</b>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR?		(City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>M.</b>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan. 6, 1956</b> to <b>Jan 28, 1956</b> , that I last saw the deceased alive on <b>Jan 28, 1956</b> , and that death occurred at <b>A M.</b> from the causes and on the date stated above. SIGNATURE <i>W. Leedom</i> ADDRESS <b>North East, Md.</b> DATE SIGNED <b>Jan 28/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>~ 31-56</b> NAME OF CEMETERY OR CREMATORIAL <b>Methodist</b> LOCATION (City, town, or county) (State) <b>North East Cecil Co Md.</b>	
DATE RECD BY LOCAL REGISTRAR <b>Jan 30</b>		24. FUNERAL DIRECTOR REGISTRATION SIGNATURE <b>H. Frazer</b> ADDRESS <b>Joseph O' Brien North East, Md.</b>	

RECEIVED

FEB 1 1967

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

498

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

MARGIN RESERVED FOR BINDING  
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE	
Cecil		Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)	
Warwick		1 day	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Benedict		1 - 5 - 56	
5. SEX		6. COLOR OR RACE	
Male		White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Single		3-16-1902	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE last birthday	
Furniture		53 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None		Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Benedict		Mary Ann Holden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT AND ADDRESS	
18. MEDICAL CERTIFICATION		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
Immediate cause		(a) Articular Fibrillation	
Antecedent cause(s)		(b) Coronary Artery disease	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
Yes <input type="checkbox"/> No <input type="checkbox"/>			

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
INJURY									
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at		HOW DID INJURY OCCUR?			
OF INJURY	m.			Work	<input type="checkbox"/>	At work	<input type="checkbox"/>		
22. I hereby certify that I attended the deceased from Jan. 5, 1955, to Jan. 5, 1956, that I last saw the deceased alive on Jan. 5, 1956, and that death occurred at 11 A.M. from the causes and on the date stated above.									
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED			
H. L. Rock. M.D. 106 S. Broad Street, Middletown Del. 1/1/56									
23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)		(State)	
Burial		1-8-56		Arlington Cemetery		Warwick Md.			
DATE REC'D BY LOCAL REG.		REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
January 7, 1956		H. L. Rock		H. L. Rock		H. L. Rock		H. L. Rock	

3 V. S

11

2

3

499

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## PLACE OF DEATH:

COUNTY

Cecil

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN Perry Point

LENGTH OF STAY  
(in this place)

7 mo. 19 days

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Veterans Administration Hospital

3. NAME OF  
DECEASED:  
(Type or Print)(First)  
EUGENE(Middle)  
(NMI)(Last)  
SHAW5. SEX:  
Male6. COLOR OR  
RACE:  
Negro7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify): Married8. DATE OF BIRTH:  
11-20-92

4. DATE (Month)

(Day)

(Year)

OF  
DEATH: January 25

19 56

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired): Head Waiter10B. KIND OF BUSINESS  
OR INDUSTRY: Mess Hall - V.A.

13. FATHER'S NAME:

Hospital  
Ephraim Shaw - Deceased15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service) Yes

16. SOCIAL SECURITY NO.

None

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

63

yrs.

Months

Days

Hours

Min.

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?  
USA

North Carolina

14. MOTHER'S MAIDEN NAME:

Julia Johnson - Deceased

17. INFORMANT &amp; ADDRESS:

Hospital Records, VAH, Perry Point, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

IMMEDIATE CAUSE

(A) DUE TO

Peritonitis diffuse

7 to 10 days

ANTECEDENT CAUSE (S)

(B) DUE TO

Carcinomatosis with rupture of the  
small bowel

unknown

(C) DUE TO

Carcinoma of the head of the pancreas

unknown

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

Pulmonary congestion and edema

3 to 4 days

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

VA

M.

22. I hereby certify that I attended the deceased from 6-6, 1955, to 1-25, 1956, ~~and saw the deceased~~~~and that death occurred at 9:40PM, from the causes and on the date stated above.~~

ADDRESS

DATE SIGNED

SIGNATURE

W. OPPLER, Director, Professional Services, V.A. Hospital, Perry Point, Md. 1-26-56

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county) (State)

Removal

1-26-56

Baltimore National

Baltimore, Md.

DATE REC'D BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-27-56

Doris E. Daugherty

Perry Point, Md., Hotel de Grace, Md.

BUFEAU V. S

JAN 30 19

15

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 92

## 1. PLACE OF DEATH:

COUNTY

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

MARYLAND

LENGTH OF STAY  
(at this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Dogwood Road.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits write RURAL and give nearest town)  
OR  
TOWNSTREET  
ADDRESS

(If rural, give location)

Dogwood Road.

3. NAME OF  
DECEASED:  
(Type or Print)

Gyles

(Middle)

Soule

(Last)

1

31

1966

1

31

1966

## 5. SEX:

M.

6. COLOR OR  
HAIR7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if not now employed)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?

13. FATHER'S NAME:

Herbert E Soule

14. MOTHER'S MAIDEN NAME:

Grand Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.)(If Yes, give war or dates of  
service)

16. SOCIAL SECURITY NO.:

17. INFORMANT &amp; ADDRESS:

Pippin Funeral Home Elton

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

9160

Immediate cause (a) ....

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, (b) ....

giving rise to the above cause DUE TO

stating underlying cause last (c)

19. IL. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes  No 

21a. EXTERNAL CAUSE WAS

PRIMARY  OR CONTRIBUTING 

CAUSE OF DEATH.

21b. PLACE (Home, farm, factory,  
OF street, bridge, etc.)

INJURY

21c. CITY OR TOWN

(County)

(State)

21d. TIME (Month) (Year)

21e. INJURY OCCURRED

OF

INJURY

While at

Not while

at work

at work

21f. HOW DID INJURY OCCUR?

Overheated stove Set fire to shack

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection  Inquiry  andfind that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE

Ole Dodson

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

DATE SIGNED

1-31-66

23. BURIAL, CREMATION,  
REMOVAL (Specify)

24. DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

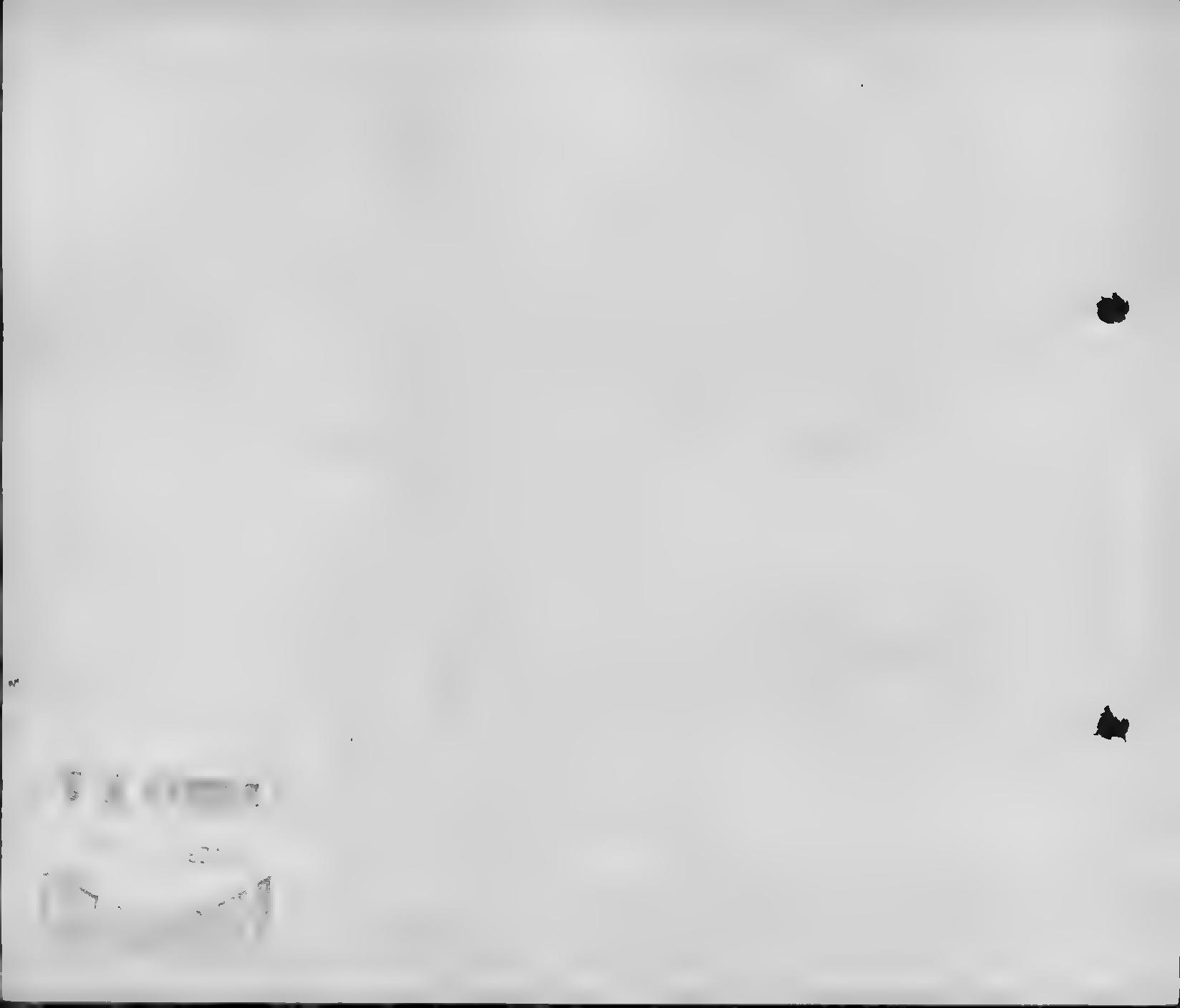
25. DATE REC'D BY LOCAL  
REG.

REG.

26. REGISTRAR'S SIGNATURE

27. FUNERAL DIRECTOR

ADDRESS



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

521

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

00450

## 1. PLACE OF DEATH:

COUNTY Cecil

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)LENGTH OF STAY  
(in this place)

TOWN Perry Point

2 mo. 27 days

HOSPITAL OR  
INSTITUTION OR

STREET ADDRESS Veterans Administration Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE D.C.

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN

Washington

47 X -?

STREET  
ADDRESS

(If rural give location)

5200 Kansas Avenue, N.W.

3. NAME OF  
DECEASED:  
(Type or Print)

(First) LAWRENCE

(Middle) W.

(Last) TRUMBULL

## 4. SEX:

Male

6. COLOR OR  
RACE:

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify):

Divorced

## 8. DATE OF BIRTH:

12-4-95

9. AGE last birthday  
IF UNDER 1 YEAR

60

yrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired)

Clerk

10B. KIND OF BUSINESS  
OR INDUSTRY:

Government Printing

## 11. BIRTHPLACE (State or foreign country):

Virginia

12. CITIZEN OF WHAT  
COUNTRY?

USA

## 13. FATHER'S NAME:

Frank Trumbull (Deceased)

## 14. MOTHER'S MAIDEN NAME:

Aurglia Curtis (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no, or unk.) (If Yes, give war or dates  
of service)

Yes

WW-1

## 16. SOCIAL SECURITY NO.

Unknwon

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

955 X  
IMMEDIATE CAUSE(A) Hemorrhage from cerebral vessels  
DUE TO due to Trauma (Electric Shock)INTERVAL BETWEEN  
ONSET AND DEATH

2 Minutes

## ANTECEDENT CAUSE (S)

(B) \_\_\_\_\_  
DUE TO  
(C)DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

Arteriosclerotic Cardiovascular Disease

10 Years

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, notify medical examiner)21B. PLACE (Home, farm, factory,  
street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

## 21E. INJURY OCCURRED

## 21F. HOW DID INJURY OCCUR?

While  Not while   
at work  at work 

22. I hereby certify that I attended the deceased from 10-17, 1955, to 1-13, 1956, and that death occurred at 9:05AM, from the causes and on the date stated above.

Signature  
Joseph C. Grasberger, Acting Chief,

ADDRESS

DATE SIGNED

JOSEPH C. GRASBERGER, Professional Services, D. V.A., Perry Point, Md.

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIUM

## LOCATION (City, town, or county)

(State)

Removal

1-13-56

Arlington National

Arlington, Virginia

DATE REC'D BY LOCAL  
REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

1-13-56

Dene E. Dougherty

W.W. CHAMBERS, 1400 Chapin St, N.W.

Wash., D.C.

BUREAU Y

JAN 17 1960

RECEIVED

52

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

COUNTY CECIL

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN PERRY POINT

LENGTH OF STAY  
(In this place)

7 DAYS

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Veterans Administration Hospital

3. NAME OF  
DECEASED:  
(Type or Print)

(First) JOHN

(Middle) HENRY

(Last) WALKER

5. SEX.

Male

6. COLOR OR  
RACE:  
(Specify): Negro7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.8. DATE OF BIRTH:  
Married May 5, 189510A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired): Waiter10B. KIND OF BUSINESS  
OR INDUSTRY:  
RR Dining Car

13. FATHER'S NAME:

George Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates  
of service) Yes WW-I

16. SOCIAL SECURITY NO.

719 07 0641

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

421X  
IMMEDIATE CAUSE(A) Bronchopneumonia, bilateral unresolved  
DUE TOINTERVAL BETWEEN  
ONSET AND DEATH

2 to 3 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.(B) Myocardial fibrosis  
DUE TO

Unknown

(C) Coronary Sclerosis

Unknown

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis, generalized, severe

Unknown

## 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21A. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, notify medical examiner)21B. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)  
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
While  Not while   
at work  at work 

21F. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from Jan. 13, 1956, to Jan. 20, 1956, ~~and that death occurred at 6:15 P.M. from the causes and on the date stated above.~~~~and that death occurred at 6:15 P.M. from the causes and on the date stated above.~~  
SIGNATURE: E. S. ELLS, Acting DirectorDATE SIGNED  
1-21-56

E. S. ELLS, M.D., Professional Service.

M.D. VAH, Perry Point, Md.

23. BURIAL, CREMATION, DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county) (State)

REMOVAL

1-22-56

Arlington National

Ft. Myer, Virginia.

DATE REC'D BY LOCAL  
REGISTRAR  
1-24-56REGISTRAR'S SIGNATURE  
Denee E. Daugherty24. FUNERAL DIRECTOR  
J. PENNINGTON & SONADDRESS  
Havre DeGrace, Md.

BUREAU C

AN

REGISTRATION



S. A. PRENTISS

475

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH: COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR TOWN <u>Elkton</u> ) LENGTH OF STAY (in this place) <u>1 day</u>		CITY: (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chidiock</u> (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS	
3. NAME OF DECEASED: (First) <u>Ella</u> (Middle) <u>White</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 24 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 20 1906</u>
9. AGE last birthday 9 yrs.		10. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Andy Andrews</u>	
14. MOTHER'S MAIDEN NAME: <u>Lucy Hester</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Robert C. White</u>	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>491X</u> IMMEDIATE CAUSE <u>Bronchitis pneumonia</u> ANTECEDENT CAUSE (S) (A) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <u>—</u> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>—</u> STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Thrombosis</u>			
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1/22</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) INJURY OCCUR?		(County) <u>—</u> (State) <u>—</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		—	
22. I hereby certify that I attended the deceased from <u>1954</u> to <u>Jan. 24, 1956</u> that I last saw the deceased alive on <u>Jan. 23, 1956</u> and that death occurred at <u>Elkton</u> M. from the causes and on the date stated above. SIGNATURE <u>Donald F. Frazer</u> M.D. ADDRESS <u>Elkton, Md.</u> DATE SIGNED <u>Jan. 24, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-26-56</u> NAME OF CEMETERY OR CREMATORIAL <u>Union Cemetery</u> LOCATION (City, town, or county) <u>Elkton (Rural)</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 25</u>		REGISTRAR'S SIGNATURE <u>H. Frazer</u> 24. FUNERAL DIRECTOR ADDRESS <u>Joseph R. Grant North East, Md.</u>	

RECEIVED

JAN 27 1956

476

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

COUNTY

CECIL

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

ELKTON

LENGTH OF STAY  
(in this place)

2 days.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

65

Union Hospital

3. NAME OF  
DECEASED:  
(Type or Print)

KAREN S.

(Middle)

(Last)

5. SEX:

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify):

8. DATE OF BIRTH:

9. AGE last birthday

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):10B. KIND OF BUSINESS  
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates  
of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS:

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

571.0

IMMEDIATE CAUSE

(A) DUE TO

ANTECEDENT CAUSE (\$)

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

Acute metabolic acidosis

24 hours.

Acute gastro-enteritis

48 hours.

? Undetermined infection?

Four weeks.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH, BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

Nutritional anemia

Four weeks.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

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BUREAU V. S

JAN 9 1966

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